Date released: _____

To be released from: Salem Radiology
31 Stiles Road
Salem NH 03079

For the purpose of: _____

Including the following portions of the record (s): Imaging/Radiology

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. This facility is released and discharged of any liability, and undersigned will hold the facility harmless, for complying with this **Authorization for Release of Medical Information.**

This authorization expires 60 days from the below date, and covers only treatment periods above.

Signed:_____ Witness: _____

Identification: _____ Date: _____

NOTICE to the person or agency receiving information: Federal laws and regulations prohibit redisclosure of the information whose confidentiality is protected in the absence of specific consent of the patient or person authorized to consent for the patient.

Fee/Charges will comply with all laws and regulations applicable to release of information.